HB1688 Policy and Design Workgroup
Meeting Synopsis – Updated 10-31-23
October 23, 2023

A. Outstanding Action Items

1. List of BHCS agencies / facilities

   Question:

   How often are updates made to the lists of crisis triage, stabilization and detox providers and how will commercial carriers be notified of these updates?

   Answer:

   1) To find active Mobile Crisis Response agencies/providers, the BH-ASO in the associated Region should be the primary source of information.
   2) As a secondary source for Mobile Crisis Response agencies / providers and as primary source for all other Behavioral Health Crisis Service providers and facilities, Department of Health (DOH) maintains the list of Behavioral Health Agencies and Facilities. (Agencies/ providers/ facilities in DOH's list may not be Active.)

      Directory: https://doh.wa.gov/sites/default/files/2022-02/606019-BHADirectory.pdf

      Selection Tool: https://doh.wa.gov/licenses-permits-and-certificates/facilities-z/behavioral-health-agencies-bha/find-bha
   3) To confirm that the license of an agency / provider / facility is still active - https://fortress.wa.gov/doh/providercredentialsearch/

B. New Action Items

1. Taxonomy Codes on 837 claims

   Background

   In situations where a provider has a State Taxonomy Code, on the 837 claim the BH-ASO will:

   - Report either "101Y00000X" - Counselor or "390200000X" - Student in the Taxonomy Code field on the 837.
   - Report the state assigned Taxonomy Code in the NTE field on the 837, either at the claim level or line level whichever is most appropriate. The message in the NTE field will be "Wash State Taxonomy Code #xxxxxxxxL"

Question:

For at least some health plans that follow CMS billing standards, the "390200000X" – Student Taxonomy Code is not something that is currently payable. A student is defined as an individual who participates in an accredited educational program (e.g., a medical school) that is not an approved Graduate Medical Education (GME) Program. Some health plans have payment policies that allow associate practitioners (defined as a pre-licensure candidate who has a graduate degree in a mental health field under RCW 18.225.090 and gaining experience necessary to become licensed independent practitioner) to be billed under the fully-licensed/credentialed supervisor but this is not universal.

For Behavioral Health Crisis Services, does the legislation / regulation require payment when services are billed under a "Student" practitioner? How is "Student" being defined by behavioral health crisis providers?

Answer: RCW 48.43.005 defines "health care provider" as "a person regulated under Title 18 or chapter **70.127** RCW, to practice health or health-related services or otherwise practicing health care services in this state consistent with state law." A pre-licensure candidate who has an associate license under RCW 18.225.145 would be considered a person "regulated under Title 18". The care must be provided in a manner that is consistent with state law, i.e. RCW 18.225.145.

It is OIC's understanding that as part of the consensus developed for implementation of E2SHB 1688, carriers will accept as sufficient for credentialing a behavioral health emergency services provider, as defined in RCW 48.43.005, that is licensed in good standing with DOH. This includes the named facilities and mobile crisis response teams, which are associated with a behavioral health agency licensed by DOH. If a health care provider holding an associate license under RCW 18.225.145 is employed by a behavioral health emergency services provider, that associate license holder would be able to bill for emergency services, as defined in RCW 48.43.005.

2. Utilization Management Requirements for HB1688

Question:

What are the UM requirements will be for the 1688 services? Is there any allowance for prior auth?

Answer: There are no pre-authorization requirement for emergency services. There is a requirement for providers to notify the appropriate commercial carrier upon an admission.

Question: Are there continuing stay UM requirements?

a. Withdrawal Management: Assumption: 5 days is the initial authorization period for Medicaid

After 5 days, what if any, are provider notification requirements for a continued stay?

Answer: For commercial health plans, RCW 48.43.005(47) defines utilization review as "the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees." Prior authorization is a distinct component of utilization review. RCW 48.43.093 prohibits commercial health plans from requiring prior authorization for receipt of emergency services. It does not prohibit a carrier undertaking concurrent review during the time that an individual is receiving services in a facility. However, RCW 48.43.761 governs carrier practices related to utilization review for withdrawal management services. It requires that a carrier provide coverage for no less than 3 days in a behavioral health agency that provides withdrawal management services prior to conducting a utilization review.

OIC would also note that a carrier's concurrent review policies to inpatient behavioral health services must comply with MHPAEA, i.e. a carrier's policies related to concurrent review for behavioral health services must be comparable to and no more stringent than their policies related to concurrent review for medical/surgical services, both as written and in operation.

b. Evaluation & Treatment (E&T) and Crisis Stabilization. Assumption: 14 days is the initial authorization period for Medicaid

After 14 days, what if any, are provider notification requirements for a continued stay?

Answer: For commercial health plans, RCW 48.43.005(47) defines utilization review as "the prospective, concurrent, or retrospective assessment of the necessity and appropriateness of the allocation of health care resources and services of a provider or facility, given or proposed to be given to an enrollee or group of enrollees." Prior authorization is a distinct component of utilization review. RCW 48.43.093 prohibits commercial health plans from requiring prior authorization for receipt of emergency services. It does not prohibit a carrier undertaking concurrent review during the time that an individual is receiving services in a facility.

OIC would also note that a carrier's concurrent review policies to inpatient behavioral health services must comply with MHPAEA, i.e. a carrier's policies related to concurrent review for behavioral health services must be comparable to and no more stringent than their policies related to concurrent review for medical/surgical services, both as written and in operation.

With respect to provider notification of a carrier regarding an admission, RCW 48.43.093 provides as follows:

(3) Nothing in this section is to be construed as prohibiting a health carrier from:

(a) Requiring notification of stabilization or inpatient admission within the time frame specified in its contract with the hospital or behavioral health emergency services provider or as soon thereafter as medically possible but no less than twenty-four hours; or
(b) Requiring a hospital or emergency behavioral health emergency services provider to make a documented good faith effort to notify the covered person's health carrier within 48 hours of stabilization, or by the end of the business day following the day the stabilization occurs, whichever is later, if the covered person needs to be stabilized. If a health carrier requires such notification, the health carrier shall provide access to an authorized representative seven days a week to receive notifications.

C. Discussion Topic: Progress Toward Implementation

What is the status of a January 1, 2024 implementation of the consensus recommendations in the Regions of King County, Thurston-Mason, Carelon?

1) The process of Carrier contracting with the BH-ASOs is underway, and for each of the three Regions there is at least one contract that is currently being negotiated. Carriers are also directing contracting efforts directly at agencies / providers.

2) BH-ASOs need some lead time in order to complete the contracting process on their end. 15 days, especially around the holidays, will not be sufficient.

3) Carriers have until the end of the year to have their network in place for 2024. OIC encourages carriers to file AADR related information as early as possible.

4) As of October 2, HCA has updated the SERI Guide and the associated BH Codes for Crisis Services spreadsheet. Once the materials are posted on the HCA website, a communication message will be sent to AWHP. The updated BH Codes for Crisis Services spreadsheet can be found on the 1688 BHCS website.

D. Next Scheduled Meeting: November 13th, 1:30 – 3:30 (if/as needed)